Central East **LHIN**

Reaching the Quality Summit

Engaged Communities. Healthy Communities.
Central East LHIN 2011-12 Annual Report

Ontario
Local Health Integration Network

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)

The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the sixth Annual Report for the LHINs with their full authorities.

For more information about LHINs, including frequently asked questions, visit the Central East LHIN web site at www.centraleastlhin.on.ca.

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MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report – "Reaching the Quality Summit" – takes its title from the LHIN's May 2011 Symposium.

Being a critical part of the evolution of health care in Ontario, LHINs are continuing to work with their communities to develop a quality system that is patient-focused, results-driven, integrated and sustainable.

This year's annual report once again demonstrates how LHINs are facilitating effective and efficient integration of health care services, thus making it easier for people to get the best care in the most appropriate setting, when they need it. The Central East LHIN has continued to realize this mandate through community engagement, local health system planning, funding and allocation, and accountability and performance management.

System goals which were articulated by the government – improve access to emergency department care by reducing the amount of time that patients spend waiting in the emergency department, improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds and improve access to integrated diabetes care – were translated into the LHIN's two Strategic Aims - *Save 1,000,000 hours spent by patients in hospital Emergency Departments by 2013 and Reduce the impact of Vascular Disease by 10% by 2013.* In 2011/12 these system goals and strategic aims again guided the collective activities of the LHIN and health care providers as documented in this Annual Report.

As always we would like to thank the hundreds of health service providers – doctors, nurses, allied health, support staff, administrators and volunteers – who dedicate themselves to their patients, clients, consumers and their families.

With their support we were able to implement many of the innovative programs detailed in this report. We look forward to sharing updates on our collective progress in the coming months and years.

Wayne Gladstone,
Chair

Deborah Hammons,
Chief Executive Officer

MEMBERS OF THE BOARD

Front Row

Margaret Risk, Member
Term of Office:
May 17, 2011 – May 16, 2014

Second Row

Valmay Barkey, Member
Term of Office:
June 2, 2011 – June 1, 2014

Third Row

Chuck Powers, Member
Term of Office:
June 2, 2011 – June 1, 2014

Fourth Row

Joanne Hough, Member
Term of Office:
May 4, 2011 – May 3, 2014

Wayne Gladstone, Chair
Term of Office:
June 2, 2010 – June 1, 2011 (Member)
June 2, 2011 - June 14, 2013 (Chair)

David Sudbury, Member
Term of Office:
June 17, 2010 – June 16, 2013

Samantha Singh, Member
Term of Office:
June 17, 2010 – June 16, 2013

David Nichols, Member
Term of Office:
February 17, 2010 – February 16, 2013

Foster Loucks, Chair
Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011

Joseline Sikorski, Vice-Chair
Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011

Jean Achmatowicz MacLeod, Secretary
Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011

Ronald Francis, Member
Term of Office:
May 17, 2006 – May 16, 2008
Reappointed:
May 17, 2008 – May 16, 2011

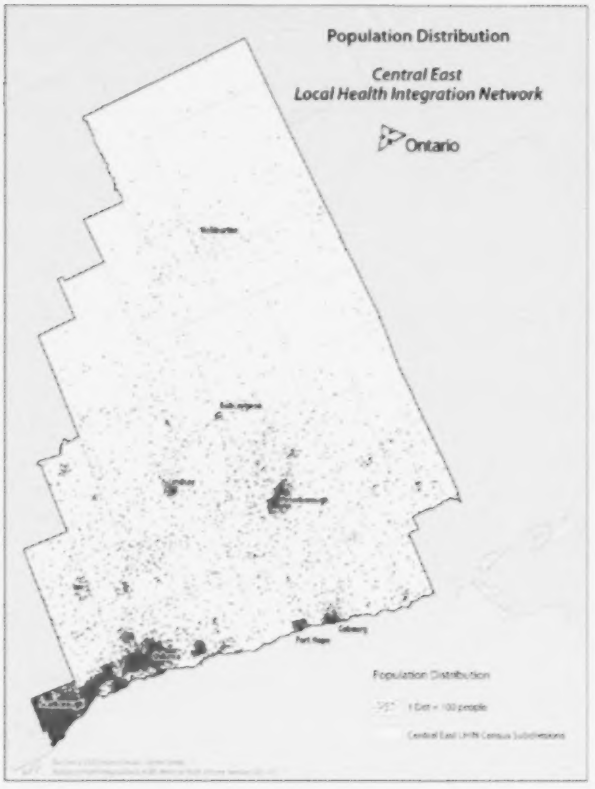
The governance structure for the LHINs is set out in the Local Health System Integration Act, 2006. LHINs operate as not-for-profit organizations governed by a board of directors appointed by the province. Each LHIN has a maximum of nine board members appointed by the Lieutenant Governor in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and at least one Vice-Chair from among the members. The board of directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The board may pass by-laws and resolutions and may establish committees. Certain by-laws may require the Minister's approval. Details on the Central East Board of Directors can be found on the Central East LHIN web site at: http://www.centraleastlhin.on.ca

INTRODUCTION

The Central East LHIN is one of 14 Local Health Integration Networks that have been established by the Government of Ontario as community-based organizations to plan, co-ordinate, integrate and fund health care services at the local level including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres.

The Central East LHIN is one of the fastest growing geographic regions in the province and home to approximately 11% of Ontario's population. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park!

Population Map



Source: MOHLTC Health Analytics Branch

It should be noted that the Durham cluster has had a 22.4% increase in population over the past 10 years with seniors over the age of 65 providing the greatest increase in growth between now and 2030. Population diversity is concentrated in the western portion of the Central East LHIN (Scarborough and West Durham clusters) with 45% of the population not having English or French as their mother tongue. The Central East LHIN also has the second highest percentage in the province of families with children headed by a single parent and the third highest unemployment rate, resulting in related increases for mental health services for our community agencies as well as decreases in non-LHIN revenues for our hospitals.

	CENTRAL EAST LHIN	ONTARIO	LHIN Range[1]
Total population (2006)	1,432,705	12,160,282	34,130-208,035
Senior population, age 65+	13.7	13.6	9.4-17.2
Population with English mother tongue	72.1	69.8	51.5-91.5
Population with French mother tongue	1.4	4.4	1.0-23.9
Population who are immigrants	33.3	28.3	6.3-47.9
Population who are recent immigrants (2001-2006)	5.6	4.8	0.3-9.5
Population who are visible minorities	34.5	22.8	1.4-50.3
Population of Aboriginal identity	1.2	2.0	0.4-18.8
Labour force participation rate (15+)	65.6	67.1	60.1-71.5
Unemployment rate (age 15+)	7.3	6.4	5.2-8.4
Population in low income	16.1	14.7	9.6-24.0
Families (with children) headed by a lone parent	26.0	24.5	20.0-30.9
High school graduates aged 25 to 29	89.3	89.7	79.1-93.0
Post-secondary graduates aged 25 to 54	61.1	63.5	55.3-71.9

Source: 2006 Census of Canada, Statistics Canada [1] *Range refers to the range of values within the 14 LHIN areas.*

MINISTRY/LHIN PERFORMANCE AGREEMENT (MLPA)

What is an MLPA?

The Central East Local Health Integration Network (Central East LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed a performance agreement which defines the obligations and responsibilities of both the LHIN and the Ministry over a defined period of time. The Ministry/LHIN Performance Agreement (MLPA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and Reporting. The MLPA is mirrored in the Accountability Agreements that LHINs have now negotiated with all health service providers.

MLPA Performance Indicators

The *Ministry-LHIN Performance Agreement* sets out the mutual understandings between the Ministry of Health and Long-Term Care and the Central East LHIN of their respective performance obligations in the period covering the 2011/12 fiscal year. The following table outlines Central East LHIN performance against targets for 2011/12.

Central East LHIN MLPA Performance Indicators 2011/12

Performance Indicator	LHIN Starting Point 11/12	LHIN Performance Target – 11/12	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care					
1. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	**20.22%**	14.80%	17.70%	**19.6%**	**17.35%**
2. 90th Percentile ER Length of Stay for Admitted Patients	**51.62**	39.00	48.00	**23.1%**	**44.53**
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	**7.40**	7.00	6.90	**-1.4%**	**6.83**
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	**4.50**	4.00	4.40	**10.0%**	**4.33**
Surgical Wait Times					
5. 90th Percentile Wait Times for Cancer Surgery	**48**	49	47	**-4.1%**	**47**
6. 90th Percentile Wait Times for Cardiac By-Pass Procedures	**NA**	NA	NA	**NA**	**NA**
7. 90th Percentile Wait Times for Cataract Surgery	**153**	140	106	**-24.3%**	**114**
8. 90th Percentile Wait Times for Hip Replacement	**190**	179	136	**-24.0%**	**163**
9. 90th Percentile Wait Times for Knee Replacement	**187**	179	151	**-15.6%**	**166**
Diagnostic Wait Times					
10. 90th Percentile Wait Times for Diagnostic MRI Scan	**102**	63	67	**6.3%**	**83**
11. 90th Percentile Wait Times for Diagnostic CT Scan	**28**	28	22	**-21.4%**	**23**
Excellent Care for All/Quality					
12. Readmission within 30 Days for Selected CMGs**	**14.77%**	14.50%	15.08%	**4.0%**	**15.74%**
Mental Health and Substance Abuse					
13. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	**17.50%**	16.60%	18.84%	**13.5%**	**18.66%**
14. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	**19.60%**	19.00%	22.29%	**17.3%**	**21.87%**
Access to Community Care					
15. 90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)	**42.00**	39.90	55.00	**37.8%**	**56.00**

Note: ***A negative percentage means that the LHIN is below its target.**
**** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 – Q2 2011/12) due to availability**
*****FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 – Q3 2011/12) due to availability**

At the end of 2011/12, the Central East LHIN was able to **achieve six performance targets** identified in its MLPA. A description of these six targets and an explanation for the achievements follows:

Performance Indicator #3 – TARGET MET
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients
Nine of the 13 hospitals operating Emergency Departments in the Central East LHIN are designated P4R (Pay for Results) hospitals. Enhanced staffing and process improvements provided through this funding stream have led to maintained Emergency Department times for high acuity patients that meet the newly reduced provincial target of 7 hours.

Performance Indicator #5 – TARGET MET
90th Percentile Wait Times for Cancer Surgery
Significant effort to engage with hospitals and their leadership in 2011/12 on Data Quality Improvement Initiatives meant that the Central East LHIN met this performance indicator and exceeded the target by an additional two days. This engagement included education sessions with administrative and clinical leaders and chart audits. Also incorporating this Wait Time Performance Indicator into each hospital's Accountability Agreement, with specific negotiated targets, ensured that efforts were undertaken to improve performance.

Performance Indicator #6 – TARGET N/A
90th Percentile Wait Times for Cardiac By-Pass Procedures
Not Applicable

Performance Indicator #7 – TARGET MET
90th Percentile Wait Times for Cataract Surgery
As noted above, significant engagement on Data Quality Improvement Initiatives and incorporating this Wait Time Performance Indicator into each hospital's Accountability Agreement has led to the Central East LHIN meeting and exceeding this target in 2011/12. Funding for an additional 543 cases also supported the system in achieving this result.

Performance Indicator #8 – TARGET MET
90th Percentile Wait Times for Hip Replacement
Similar to Cancer Surgery – see text above.

Performance Indicator #9 – TARGET MET
90th Percentile Wait Times for Knee Replacement
Similar to Cancer Surgery– see text above.

Performance Indicator #11 – TARGET MET
90th Percentile Wait Times for Diagnostic CT Scan
In 2011/12, the addition of two replacement and one re-purposed CT machine (in the ER) at The Scarborough Hospital helped to support the LHIN's targets. Ongoing engagement with the LHIN's Diagnostic Imaging Group (leads from each hospitals) on Data Quality Improvement Initiatives, education sessions with administrative and clinical leaders, chart audits and incorporating this Wait Time Performance Indicator into each hospital's Accountability Agreement with specific negotiated targets supported the LHIN to meet and exceed this target.

At the end of 2011/12, the Central East LHIN was **unable to achieve eight performance targets** identified in its MLPA. A description of these eight targets and an explanation for the variance follows:

Performance Indicator #1 – TARGET UNMET
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:
While the Central East LHIN did not meet the performance target of 15.9%, significant and sustainable reductions in Alternate Level of Care days were realized in the Central East LHIN. The Central East LHIN was one of eight LHINs in Ontario where reductions in ALC were realized. This improvement was for the most part due to the implementation of the Home First philosophy across all Central East LHIN hospitals. Home First is designed to reduce the overall volume of ALC designated patients at every hospital, and eventually this reduction in cases will result in a reduction in %ALC. However, this reduction will take time to occur, as the discharge of ALC-designated patients cannot be hastened, but depends upon Long Term Care Home bed availability and post-acute capacity such as home care, rehabilitation services, and assisted daily living programs.

Performance Indicator #2 – TARGET UNMET
90th Percentile ER Length of Stay for Admitted Patients
Despite not meeting the target of 39 hours, there were significant and sustainable improvements in this category. Beginning the year with ER Length of Stay for Admitted patients at 52 hours – the year end overall performance was 44 hours. Up until the last quarter of the 2011-12 year, there were three consecutive periods of improvement in this measure. The limiting factor for the flow of admitted patients through the hospital is inpatient capacity. As the business processes involved in Home First are embedded and sustained at each Central East LHIN hospital, the overall volume of ALC patients will be reduced, thus increasing the capacity available to inpatients waiting in the ED. We expect a substantial reduction in this time in FY2012. Central East LHIN continues to focus on system-wide flow as described in the Central East Home First business processes (admission avoidance, patient activation, early engagement of CCAC and CSS, and prompt discharge of patients back into the community). Establishment of an electronic Resource Matching &Referral process is expected to further contribute to these successes.

Performance Indicator #4 – TARGET UNMET
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients
Performance in this indicator has had little fluctuation over the last year. Length of Stay was slightly over the MLPA target of 4.0 hours. Central East LHIN had the 8th shortest in the province by year end – with little variation across all 14 LHINs.

Performance Indicator #10 – TARGET UNMET
90th Percentile Wait Times for Diagnostic MRI Scan
While Magnetic Resonance Imaging (MRI) wait times performance was expected to improve once three new MRI machines at Ross Memorial Hospital, Rouge Valley Health System and The Scarborough Hospital were fully operational, wait times actually increased due to demand as patients sought this service in their local communities and facilities. During the year, the Central East LHIN invested $1.2 million to purchase 4,600 additional procedures. Volumes were reallocated among hospitals to optimize wait time performance (e.g. resulting from delays in implementation of new MRI machines.) The Central East LHIN also provided $20,000 to each of the public hospitals for data clean-up and quality improvement. Six Central East LHIN hospitals participated in the MRI Performance Improvement Process (PIP) initiative in 2011/12. These initiatives led to improved performance. Changing clinical practices have also led to an increased demand as more physicians use MRIs instead of CTs for diagnostic purposes. In 2012/13 the LHIN will be working with its hospitals and the Ministry on updating the funding formula for the new machines to enable the hospitals to respond to the growing demand.

Performance Indicator #12 – TARGET UNMET
Readmission within 30 Days for Selected CMGs
LHIN performance has improved since last reporting period and is at its best rate since the second quarter of 2010-11. Unfortunately, with only two quarters reported, we do not have a full picture of hospital readmissions in 2011-12. Also, the methodology of calculating this indicator makes it challenging to pin-point areas for improvement. A readmission can be for any reason at any hospital. Nonetheless, this is an important measure of health care effectiveness and it has gained more attention with the recent appointment of the Central East LHIN Primary Care Leads.

Performance Indicator #13 – TARGET UNMET
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
Similar to the previous indicator, with only two quarters reported, we do not have a full picture of Repeat Unscheduled Emergency Department visits for 2011-12. The Central East LHIN's performance in this area is average with the rest of the province, and very comparable to the other Toronto area LHINs. Efforts have been made to see improvements in this domain, specifically additional investments in expanding and coordinating crisis support services provided by the community and hospital partners. These programs were expanded in late 2011-12 so the data is not available to discern any change. The Schedule 1 Bed Registry, to be implemented in 2012-13, will reduce time spent in the ED by providing those who require a Schedule 1 Bed with more timely access. This will ensure that Schedule 1 hospitalizations are more effective, and that the person is repatriated to their home hospital as quickly as possible. It should mitigate the need for an unscheduled return ED visit for this group.

Performance Indicator #14 – TARGET UNMET
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions
With only two quarters reported, we do not have a full picture of Repeat Unscheduled Emergency Department visits for Substance Abuse in 2011-12. Based on the data available, the Central East LHIN performed on average with the Province and the Greater Toronto Area LHINs. Planned activities centre around the implementation of strategic Emergency Department partnerships that are focusing on supporting clients with Concurrent Disorders as this group has shown to be the most frequent to experience an repeat unscheduled Emergency Department visit. Other activities relate to building the capacity of the mental health and addictions providers system to support people with Concurrent Disorders, and expanding those efforts to the Primary Health Care System.

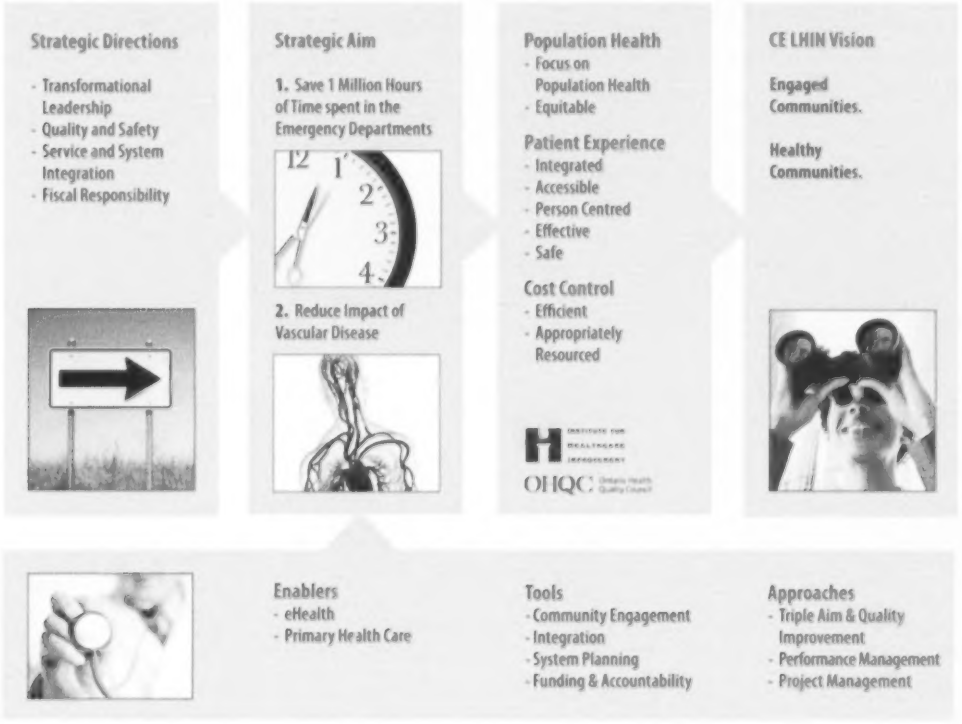
Performance Indicator #15 – TARGET UNMET
90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)
While the Central East LHIN has not met this target, further examination demonstrates that reported wait times are not always reflective of access to services, nor are they comparable to other parts of the province due to differing wait time management practices by other Community Care Access Centres. As a result of the LHINs focus on reducing Emergency Department Wait Times and Alternate Level of Care, Central East CCAC resources have been prioritized to clients requiring discharge from the Emergency Department or a hospital in-patient program. Regrettably, with the resources available to the LHIN and CCAC, this has meant long waitlists in the community for persons requiring personal support services and therapy services. However, the Central East CCAC manages the release of clients from the waitlist when funds are available by admitting the highest priority/need clients first. The wait time for these clients is significant; therefore, the average wait time for these community clients is longer than the 90th percentile. The admission of clients from the waitlist causes an increase in the wait time from assessment to initiation of service, as the wait time (days) is counted when the client is admitted. As a result of providing more access to services and reducing the wait list for therapy services, the reported wait time has increased. Access to home care services are closely monitored by the LHIN and the CCAC. Efforts have also been made to move people from the CCAC personal support service waitlist to active service under the expansion of the Assisted Living for High Risk Seniors services funded by the Central East LHIN in 2011-12.

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN (IHSP)

In 2011/12, the Central East LHIN held its fifth annual Symposium "Reaching the Quality Summit" to update the system on progress against its two strategic aims contained in the 2010/2013 Integrated Health Service Plan (IHSP):

- Save 1,000,000 hours of time patients spend in Central East LHIN emergency departments by 2013.
- Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

The Central East LHIN Strategy Map, which was included in the IHSP, highlighted how the LHIN's strategic directions of Transformational Leadership, Quality and Safety, Health Service and System Integration and Fiscal Responsibility provided the basis for decision making that would accomplish elements of a high performing system and which will achieve the vision of *Engaged Communities, Healthy Communities*.



Along with the two strategic aims, the IHSP identified segments of the population where initiatives should be prioritized. These included:

- Seniors
- People with a Mental Illness and/or Addictions
- People with Chronic Diseases
- Francophone Community and our Aboriginal partners

Implementation of the IHSP

Including ER Wait Times Initiatives/Improving the ALC Situation

Important to the health care system and to hospitals in the Central East LHIN is decreasing patient flow times for treating and discharging patients through Central East LHIN emergency departments. Additionally, placement of patients classified as Alternate Level of Care (ALC) is a priority across the province and in the Central East LHIN. ALC is a complex system issue that impacts patient access to care, patient safety, and patient quality of life. It is costly to the health and well-being of the patient and their loved ones, and it is costly to the health care system.

It was expected that with the successful implementation of the strategic aims during 2011/12, the health system would have seen:

- A reduction in emergency department demand
- An improvement in patient flow within the emergency department
- More appropriate levels of care provided in the community for patients who no longer require acute care services within the hospital, reducing ALC and improving bed utilization
- A reduction in the impact of vascular disease on individuals and the health care system
- A reduction in the number of hospital days associated with vascular diseases
- A decrease in the prevalence of co-morbidity for those patients with an existing primary chronic condition
- Improved wait times for diagnostic and surgical procedures
- Better timeliness of access to home care services

With the support of health service providers across the Central East LHIN, the following initiatives were maintained and/or implemented in 2011-12 to address these government priorities as the LHIN continued to focus the system on the achievement of the two strategic aims.

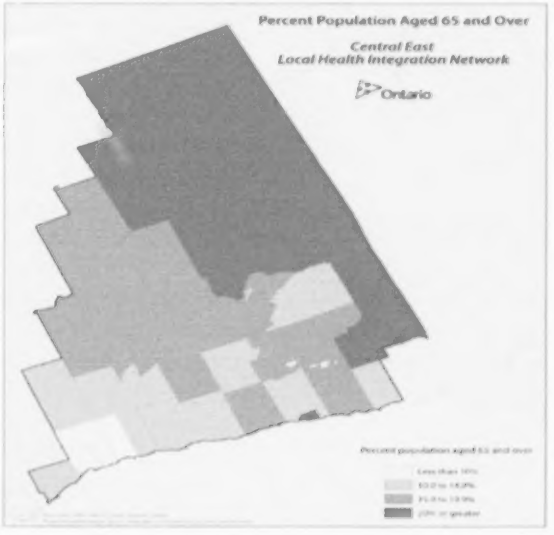
STRATEGIC AIM: Save 1,000,000 hours of time patients spend in Central East LHIN emergency departments by 2013.

Geriatric Assessment and Intervention Network (GAIN) – ongoing

In 2011/12, "Geriatric Assessment and Intervention Network" or GAIN clinics continued to operate at four Central East LHIN hospitals – The Scarborough Hospital (General site); Rouge Valley (Centenary campus); Lakeridge Health Oshawa and the Peterborough Regional Health Centre - to ensure that frail seniors received the care they needed outside of an Emergency Department setting. In 2011/12 this **"Aging at Home"** initiative has supported emergency room and community-based physicians in referring over 3,400 seniors to these clinics for follow up assessments and treatment by an inter-professional care team. The GAIN clinics are further supported by dedicated geriatric in-patient units in each of the four hospitals that enable direct access to in-patient care for frail seniors.

http://www.centraleastlhin.on.ca/Page.aspx?d=18660

Percent Population Aged 65 and over



Source: MOHLTC Health Analytics Branch

Home First - ongoing

First rolled out across the Central East LHIN in 2010/11, "Home First" is an initiative led by the Central East Community Care Access Centre (CECCAC) that helps patients transition from hospital to home. By March 2012, through partnerships with all hospitals and local community support service agencies, the CECCAC had supported over 8,481 individuals to be safely discharged from the hospital, with enhanced home care supports, so that they can make decisions related to future long term care needs in their own homes rather than a hospital bed, or remain in their home with care provided by the CCAC, community support service agencies and support by their families. This **"Aging at Home"** initiative had a significant impact on Alternate Level of Care (ALC) rates in the LHIN and will continue to be the focus of all partners in 2012/13.

http://www.centraleastlhin.on.ca/Page.aspx?id=18658

Geriatric Emergency Management Nurses - ongoing

The role of the Geriatric Emergency Management (GEM) Nurses is to deliver targeted geriatric assessments to high-risk seniors in the ED and to build capacity through knowledge transfer among ED staff and other health care partners (Regional Geriatric Program, 2009). ED staff call on the specialized GEM nurses when an elderly patient meets the criteria for an assessment. Typically – though not always – these frail seniors are aged 75 years or older and their problems might include one or more geriatric syndrome: falls, delirium, dementia, depression, elder abuse, pressure ulcers, incontinence, malnutrition and functional decline. The GEM nurse position, which began in the Central East LHIN in 2007, was introduced to the province in 2004 and has since grown from one nurse to more than 65 across the province. In the Central East LHIN, GEM nurses had over 2,000 clients referred to their care. Over 700 clients received in person clinical assessments and over 300 had telephone assessments.

Regional Specialized Geriatrics Program Development – ongoing

In late 2010/11, the LHIN began a process to establish a Regional Specialized Geriatric (RSGS) Program. Building on previous investments, including eight GEM nurses, three Nurse Practitioner Outreach Teams to Long-Term Care, post-acute transition and restorative care programs, supportive housing and the four GAIN clinics, the LHIN determined that time had come to define how these services and programs will be woven together to result in a more coordinated continuum of care for frail seniors and their caregivers. A report was presented to the Central East LHIN Board of Directors in spring 2011 which outlined directions to achieve an RSGS program in this region and the inaugural governance authority was created in January 2012.

http://www.centraleastlhin.on.ca/Page.aspx?id=7096

Timely Access for Seniors to Hospital and Community-based Services - ongoing

Funding made available through the province including the **"Aging at Home"** strategy allowed the LHIN to make a number of investments in 2011/12 that had an impact on the LHIN's aim of saving time in the Emergency Departments and its focus on Seniors. These included:

- a $0.8M investment to enable the removal of barriers to discharge that community support service agencies can fulfill. This includes removal of any client fees associated with a community support service if it is deemed a barrier to an individual leaving the hospital;
- the recruitment of community support service "Supported Referral Coordinators" to be located directly within the three CCAC intake centres in Central East;
- commencement of the planning for an ALC Resource Matching and Referral solution which is an electronic information and referral system that automates and standardizes the referral process and matches patients/clients to the program or services that best meets their individual needs;
- expansion of the Home at Last Program – an additional 412 new "Home at Last" settlements (25% increase);
- 45 new Adult Day Program Spaces;
- five new fulltime Nurse Practitioners to support Palliative Care clients in the community;

- 20 new BSO (Behavioural Supports Ontario) nurses and 30 Personal Support Workers to support the rollout of the BSO service delivery model in local long term care homes;
- expanding the use of the Ontario Telemedicine Network in hospitals, community health centres and community support service agencies through an investment in capital equipment and 20 new nursing positions;
- supporting 120 new clients to receive Assisted Living for High-Risk seniors services in four LHIN communities;
- investing over $200,000 in a 8-10 bed flexible Transitional Care Program at Campbellford Memorial Hospital;
- providing nearly $500,000 to Ross Memorial Hospital to enhance its Assess and Restore program that supports patient activation and earlier discharge for seniors;
- ongoing investments in the Community Support Services sector to support their involvement in Home First.

Nurse Practitioner Outreach to Long-Term Care (NPSTAT) - ongoing
The Central East LHIN, working with the Ministry of Health and Long-Term Care, invested in three new NP outreach teams – in Scarborough, Durham and the North East cluster, which included Peterborough, Northumberland, Kawartha Lakes and Haliburton. Launched in September 2010 and continuing in fiscal 2011/12, the NP-led LTC outreach teams are collectively referred to as NPSTAT: - "Nurse Practitioners Supporting Teams Averting Transfers". The NPSTAT program was developed to address the health risks of transferring frail seniors to emergency departments for visits which could be avoided if treated in the long-term care home. Reducing avoidable hospital visits and admissions has improved the health profile and health care experience of long-term care home residents, while maintaining or reducing the cost of providing appropriate care. When LTCH residents are hospitalized, NPSTAT helps facilitate earlier discharges back to the LTCHs which can decrease hospital length of stay (LOS), enhance continuity of care and communication between acute and LTC sectors, and provide support and resources to LTCH staff to help manage repatriated LTCH residents. In 2011/12 over 4,700 transfers were averted saving over $4 million in hospital costs.
http://www.centraleastlhin.on.ca/Page.aspx?id=17706

Pay for Results Year III - ongoing
Six Central East LHIN hospitals and one community agency participated in Year III of the provincial Pay-for-Results program and were measured against goals which included time to physician assessment and time to admission. These hospitals introduced a number of process improvements, which continued in 2011/12, in order to improve their results. This included having dedicated mental health crisis workers work with local police rather than transporting patients to the emergency departments, increased crisis staffing to support evenings and weekends, the creation of a dedicated "Medical Rapid Referral Clinic" to speed up triage, treatment and discharge and dedicated lab staff to the Emergency Department to improve on turnaround times for necessary tests.
http://www.centraleastlhin.on.ca/pressrelease.aspx?ekmensel=e2f22c9a_72_190_btnlink – see July 29, 2010

Community Crisis Support for Mental Health clients – ongoing
An innovative partnership between Durham Mental Health Services (DMHS) and Rouge Valley Health System continues to lead to greater awareness of resources available in the community to clients presenting in local emergency departments and enhanced working relationships between community mental health service providers and their hospital partners. First introduced in late 2009, this program has seen the DMHS Mobile Crisis Team visit Rouge Valley's emergency departments on a daily basis to support referrals and discharges to six community–based crisis beds or to the community, with support. Onsite psychiatric consultation, which started in early 2011, is provided by funding from the Ministry and the LHIN so that adults and youths can receive weekly psychiatric support through scheduled appointments. http://www.dmhs.ca/files/crisis.pdf

Admissions‡, discharges†, acute and total days† and average lengths of stay in designated mental health facilities, Central East LHIN hospitals and Ontario, 2009/10

Hospital	Admissions ‡	Discharges†	Acute Days†	Average Acute Length of Stay†	Total Days (excl. days away)†	Average Total Length of Stay (excl. days away)†
(4541) LAKERIDGE HEALTH CORPORATION-OSHAWA SITE	851	840	10,681	12.7	10,612	12.6
(4552) PETERBOROUGH REGIONAL HEALTH CENTRE	684	688	8,809	12.8	8,800	12.8
(4572) ROUGE VALLEY HEALTH SYSTEM-CENTENARY	1,262	1,241	14,606	11.8	14,690	11.8
(4573) SCARBOROUGH HOSPITAL (THE)-GRACE SITE	1,153	1,144	12,091	10.6	12,819	11.2
(4574) SCARBOROUGH HOSPITAL (THE)-SCAR.GEN.SITE	167	185	2,688	14.5	2,704	14.6
(4579) ONTARIO SHORES CTR FOR MENTAL HLTH SCIENCE	556	567	90,861	160.2	95,836	169.0
(4593) ROSS MEMORIAL HOSPITAL	410	414	4,404	10.6	4,269	10.3
Central East LHIN Total	**5,083**	**5,079**	**144,140**	**28.4**	**149,730**	**29.5**
Ontario Total	**51,214**	**51,210**	**1,326,077**	**25.9**	**1,329,927**	**26.0**

‡Admissions refer to cases that were admitted during the 2009/10 fiscal year

†Discharges, days and average lengths of stay are for cases discharged during the 2009/10 fiscal year, regardless of the year of admission. Acute days and average acute length of stay include the days when the patient was away from the mental health bed; total days and average total length of stay exclude the days when the patient was away from the mental health bed

Source: Inpatient Adult Mental Health Table, [Ontario Mental Health Reporting System (OMHRS)], Intellihealth Ontario, Ministry of Health and Long-Term Care, Retrieved May, 2011.

Note that as of FY2006/07, adult mental health activity in designated beds is collected through the OMHRS and not the Discharge Abstract Database (DAD)

eHealth projects - ongoing

The **Timely Discharge Information System (TDIS)** ensures that family doctors and other community physicians receive information concerning a patient's hospital stay within 72 hours of transcription from the hospital. The number of reports available through TDIS grew from 1,411 in October of 2010 to 167,404 total reports in 2011/12. This included reports on patients' health information and their diagnostic imaging reports. A **Surgical Utilization Management Integration Tool (SUBMIT)** provides an electronic solution to improving wait list management for Central East LHIN surgeons and support accurate reporting on Wait Times for surgical procedures.
http://www.centraleastlhin.on.ca/Page.aspx?id=11808

At the end of 2011/12, the Central East LHIN was projecting that the system will have saved a cumulative total of 443,276 hours of time patients spend in Central East LHIN Emergency Departments by 2013.

STRATEGIC AIM: Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

Strategic Aim Coalitions

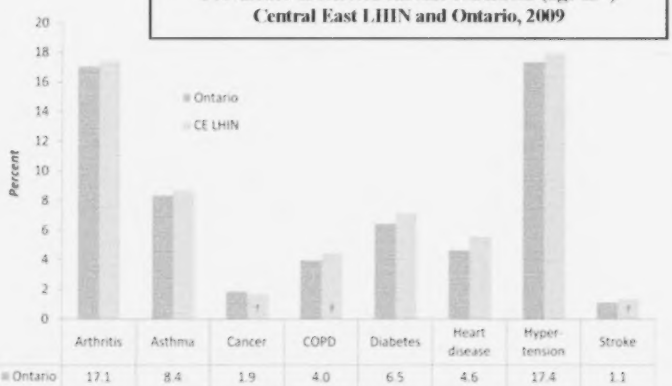
First established in May 2010, coalitions were formed to provide leadership to the achievement of the LHIN's Strategic Aims. The *Vascular Health Strategic Aim Coalition* is comprised of fifteen individuals from primary care, acute, community and long-term care home sectors. During 2011/12 the coalition developed a Vascular Health Strategy and Implementation Plan for Central East LHIN to achieve the Strategic Aim of saving 10,000 in-patient days related to bascular (including diabetes) conditions. To date the Coalition has surpassed its target and has saved 17,430 days. High priority Vascular Health initiatives include:

- Development of a Complex Centre for Diabetes Care
- Equitable access to best-practice Cardiovascular Secondary Prevention and Management across the LHIN
- Continued development of the LHIN wide Self Management and Self Management support program
- Development of PCI and CODE STEMI capacity in the North East cluster, specifically at Peterborough Regional Health Centre and the formal integration of existing vascular surgical services between The Scarborough Hospital and the Rouge Valley Health System and between Peterborough Regional Health Centre and Lakeridge Health
- a Central East LHIN hospital and community primary care partnership for Smoking Cessation
- Early chronic kidney disease management through Primary Care
- Use of the Ontario Telemedicine Network utilized for vascular clinical and education opportunities
- Continued development of a Central East Unified Stroke System

Self Management for Consumers/Caregivers Priority Project – ongoing

The Central East LHIN Self-Management Training Project became a permanent program within the Central East Community Care Access Centre in 2010/11. The Self-Management program delivers peer-led Stanford CDSM (Chronic Disease Self-Management) workshops, as well as training to health service providers in self-management support and other leading edge self-management-related activities. Through numerous partnerships with community and health care organizations, 84 "Living a Healthy Life" 6-week self-management workshops were delivered in 2011/12 to 1,113 participants, in English, Tamil, Mandarin and Cantonese. The program has also established strong linkages with local hospitals and primary care to support staff in developing skills which helps their patients self-manage: 30 workshops were provided to 366 clinicians in 2011/12 with additional mentorship delivered to over 130 of those providers. The work of the CE LHIN Self-Management Program was supported by the Ontario Diabetes Strategy (ODS). In 2011/12, the province supported each LHIN in Ontario through the ODS to expand self-management activities to support a shift in the health system to preparing and empowering individuals with diabetes to assume greater control and responsibility for daily health care decisions. www.healthylifeworkshop.ca

Prevalence of selected chronic conditions (age 12+)
Central East LHIN and Ontario, 2009



	Arthritis	Asthma	Cancer	COPD	Diabetes	Heart disease	Hyper-tension	Stroke
Ontario	17.1	8.4	1.9	4.0	6.5	4.6	17.4	1.1
CE LHIN	17.4	8.7	1.7†	4.4†	7.2	5.6	17.9	1.4†

Source: 2009 Canadian Community Health Survey, Ontario Share File (Statistics Canada)
COPD is calculated for those aged 35+
† Coefficient of variation 16.6% to 33.3% - interpret with caution

Prevention and Management of Diabetes in the Central East LHIN - ongoing
Over 60,000 copies of a Diabetes Resource Guide entitled *"Living with Diabetes – What you should know"*, developed by the Central East LHIN are now in circulation – available in English, French, Tamil and Cantonese. The Central East LHIN Diabetes Regional Coordination Centre now leads this on-going initiative and is collaborating with their partners in Central West and Mississauga Halton LHINs to develop a business case to make the Central East LHIN developed guide available in ten additional languages.
http://www.centraleastlhin.on.ca/Page.aspx?id=10472

Regional Kidney Disease Plan – ongoing
Since 2010, the three regional Renal Centres in the Central East LHIN (Scarborough, Durham, Peterborough) have been collaborating to identify, share and implement best practices across the LHIN – this continues under the leadership of the Central East LHIN Renal Network supported by the Ontario Renal Network (ORN). There has been success expanding access to home hemodialysis in the region, expanding access to peritoneal dialysis in Long Term Care Homes and identification of strategies to improve Arteriovenous fistula rates at all centres.

Code STEMI (ST segment Elevation Myocardial Infarction) expansion - ongoing
The LHIN supported the expansion of the Code STEMI program into Durham Region and stronger partnerships between Lakeridge Health, Rouge Valley Health System (RVHS) and Durham Region Emergency Medical Services (EMS) in 2010/11. In 2011/12 the Code STEMI program continued to provide percutaneous coronary intervention (PCI), or angioplasty, which unblocks narrowed arteries in the heart within 90 minutes of a patient presenting with cardiac symptoms, allowing more lives to be saved. In the event of specific types of heart attacks for patients in their area, Lakeridge Health's emergency department team now calls RVHS to activate the Code STEMI response. The patient is transported immediately via ambulance to the RVHS cardiac catheterization lab, located at Rouge Valley Centenary in east Toronto, for an angioplasty. Following the angioplasty, the patient is returned to Lakeridge Health's critical care department for ongoing care and recuperation.
http://www.centraleastlhin.on.ca/newsroom_display.aspx?id=15784

PCI (Percutaneous Coronary Intervention) - ongoing
In September 2011 Peterborough Regional Health Centre (PRHC) was approved as a stand-alone PCI site to serve patients in the Northeast cluster. PRHC is the second stand-alone PCI site in the Central East LHIN. PRHC began offering PCI in January 2012 and performed 144 procedures by the end of 2011/2012. PRHC will continue to provide 576 PCI procedures annually.

Regional Cardiovascular Rehabilitation Services – ongoing
Patients in Durham Region and Scarborough now have greater access to co-ordinated cardiovascular rehabilitation services after the Board of the Central East LHIN approved $1 million in funding in July 2011 to support the integration of the cardiovascular rehabilitation programs at Rouge Valley Health System (RVHS) and Lakeridge Health. The two hospitals are working together to deliver a groundbreaking regional cardiovascular rehabilitation and secondary prevention program, which will provide services annually to an additional 680 patients per year, or a total of 1,980 residents in their communities. Cardiovascular rehabilitation is offered to patients who have established vascular disease or are at risk of developing a cardiac disease. The new regional service will provide supervised exercise programs, along with education classes, counseling and support for patients and their families.

At the end of 2011/12, the Central East LHIN was projecting that the system will have reduced the impact of Vascular Disease by saving 17,430 inpatient days by 2013, far surpassing the goal of 10,000 days by 7,430 days.

Community Engagement Activities

Community Engagement is the foundation of all activity at the Central East LHIN. Being more responsive to local needs and opportunities requires on-going dialogue and planning with those who use and deliver health services. Since 2005, board members and LHIN staff have actively engaged with local community residents, health care service providers, provincial associations, local government leaders and many other organizations and individuals on how to improve and enhance the public health system.
In February 2011, the Ministry of Health and Long-Term Care approved community engagement guidelines and a toolkit to be used by all LHINs in an effort to promote consistency across the province. By developing provincial guidelines, all 14 LHINs have a consistent approach to community engagement planning and are better able to show how feedback gathered through community engagement activities is considered as part of each LHIN's decision making process.
http://www.centraleastlhin.on.ca/Page.aspx?id=130

In the guidelines, it is recognized that stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by the project, or anyone that may exert influence over the project or its results is considered a project stakeholder. For the purpose of stakeholder identification in the Central East LHIN, "communities" can be interpreted to mean geographic locations (i.e. Scarborough, Durham Region, North East), communities of interest or communities of practice.

- *Community of interest (COI)* - an informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.
- *Community of practice (CoP)* - an informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).
- *Political Entity* - For the purpose of stakeholder identification, "political entity" is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.
- *Planning Partners* – for the Central East LHIN, a Planning Partner stakeholder is defined as a group that has been formally constituted and/or is supported by the LHIN in order to facilitate engagement related to LHIN MLPA deliverables.

Community engagement also refers to the methods by which LHINs interact, share and gather information from and with their stakeholders. The purpose of community engagement is to inform, educate, gather feedback, consult, involve and empower stakeholders in both health care or health service planning and decision-making processes to improve the health care system.

- *Inform and Educate* - To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities to community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.
- *Gather Input* - To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for a community or communities to voice their opinions, express their concerns and identify modifications. There may be potential to influence the final outcome.
- *Consult* - To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between the community and the LHIN. Consultation may *result in* changes to the final outcome.
- *Involve* – To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. At this level, community stakeholders may provide direct advice as this is a two-way communication

process. This level will influence the final outcome and encourage participants to take responsibility for solutions.

- *Empower* – to allow final decision making.

(Please note that the Empower Level of Engagement rests with the government and the Board of the Central East LHIN.)

In 2011-12, refreshed and new engagement structures, introduced with the launch of the 2010-2013 Integrated Health Service Plan, ongoing engagement with our francophone and aboriginal stakeholders and the continued use of the website, open board meetings, public communication and face to face meetings supported the LHIN as it worked with local community stakeholders on enhancing the public health care system.

Francophone Initiatives

In 2010, the provincial government created a regulation under the Local Health System Integration Act (LHSIA), 2006 related to Francophone community engagement. The Central East LHIN began working with its LHIN partners – Central and North Simcoe Muskoka - on developing a partnership with the provincially-named French language health planning Entité 4 for Central South West Ontario. This has included the development of an accountability agreement between Entité 4 and the LHINs, the development of a Joint Action Plan and the creation of a liaison committee.

In 2011/12, the Central East LHIN worked with Entité 4 and its Central and North Simcoe Muskoka LHIN partners to:

- Clarify roles, responsibilities and the working relationship between Entité 4 and the LHINs, including the French Language Service Coordinators
- Engage the Francophone community on actions taken by each LHIN to achieve Integrated Health Services Plan (IHSP) strategic priorities
- Make information on French Service Providers easily accessible on the websites of each LHIN
- Identify long-term goals for improving access to French Language Services in each LHIN

A significant achievement was the delivery of two French language training modules for Peer Leader Training and Self-Management through the Central East Self Management Program run by the Central East Community Care Access Centre. The Entité will play a leadership role in the development of the LHIN's next IHSP in the summer and fall of 2012.

French-Speaking Population in Central East LHIN

Sub-LHIN Planning Zone	Population who include French as mother tongue – total responses	% of population who include French as mother tongue
Haliburton Highlands	265	1.7%
Kawartha Lakes	870	1.2%
Peterborough City and County	1,650	1.3%
Northumberland-Havelock	920	1.2%
Durham East	5,070	2.3%
Durham West	5,470	1.98%
Durham North/Central	555	1.1%
Scarborough /Agincourt-Rouge	2,250	0.8%
Scarborough Cliffs – Scarborough Centre	3,285	1.2%
Total	20,360	1.4% of CE LHIN population

Aboriginal Initiatives

In 2010/11, the Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Métis Nation of Ontario, Mississaugas of Scugog Island First Nation and the Central East LHIN established a significant partnership to benefit the health, communities and the future of First Nations, Metis, Inuit and Non-Status people.

Through two advisory groups - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN has received advice on a variety of topics related to provincial and Central East LHIN priorities and how they pertain to the First Nations people represented. In 2011/12 both advisory groups continued to meet bi-monthly, with a joint meeting of both the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee in September 2011.

Areas of focus for the First Nations Health Advisory Circle in 2011/12 included mental health and addictions, elder care and access to health data relevant to their communities. The Métis, Inuit, Non-Status People's Advisory Committee also focused on the completion of their health needs survey. This initiative was supported by the Métis Nation of Ontario, the Central East and the South East LHINs and will provide information on the self reported health needs of Métis living in Ontario by LHIN. The survey is expected to be completed in early 2012/13.

The Central East LHIN estimates that the First Nation, Métis and urban-based Aboriginal peoples residing in the region represents about one percent of the total regional population.

First Nation, Métis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Métis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional and funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.

One of the main goals of the Central East LHIN is to work with the First Nation, Métis, Inuit and Non-Status peoples to improve their overall health status. The Central East LHIN is committed to working with all Aboriginal people to align health services with existing regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes. See - http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=18144

	Central East LHIN	Ontario
Total Aboriginal Identity Population	16,390	242,490
North American Indian single response	10,525	158,400
Métis single response	5,015	73,610
Inuit single response	210	2,035
Multiple Aboriginal response	100	1,905
Aboriginal responses not included elsewhere	600	6,540
Total Aboriginal Ancestry Population	34,515	403,795
Percent Population by Aboriginal Identity	1.2%	2.0%
Percent Population by Aboriginal Ancestry	2.4%	3.4%

Census Counts of Aboriginal Identity and Aboriginal Ancestry Populations – Central East LHIN, 2006

Engagement Structures

Board to Board Engagement
The Central East LHIN Board of Directors established three Governance Advisory Councils in 2010 in the Scarborough, Durham and Northeast clusters. Membership has been open to governors from each health service provider across all sectors. Quarterly meetings are held to discuss best practices, challenges and successes encountered at each organization along with LHIN initiative updates. These meetings have advanced the dialogue and forged stronger relationships between our health service providers to establish clear messaging. Councils will continue to meet on topics involving quality improvement, patient-centred care and any other concerns that are raised by the membership. In an effort to meet the need for good governance, the Central East LHIN has supported the United Way's "Good Governance Boot camps" by encouraging all of our health service provider boards to participate in these workshops.

Central East Executive Council (CEEC)
Senior Administrators from the Central East LHIN, all Central East LHIN hospitals and the Central East Community Care Access Centre meet on a monthly basis to review shared projects and initiatives that support the system's goal of reducing ED wait time and reducing the impact of vascular disease. Guided by a memorandum of understanding, the council also considers programs, service, and back office alignment that would decrease cost, increase quality or improve patient access for service, and collectively develop human resource capacity and the opportunity to share experience.

Medical Leadership Group
Strong partnerships with hospitals' Chiefs of Staff and Chief Nursing Executives, formed during the development of the first "Clinical Services Plan", continued in 2011/12 and the LHIN continued to meet with this group to discuss system wide deliverables and the development of regional programs and initiatives.

Vice President and Chief Nursing Executive Steering Committee (VP/CNE)
The VP/CNE Steering Committee facilitates the provision of safe, quality, seamless, consistent and efficient patient care within the Central East LHIN. Through collaboration and open and joint decision making, the Steering Committee seeks out opportunities to enhance the patient experience and makes recommendations around practice directions, with the aim of optimizing patient care. The Steering Committee also seeks out opportunities for ongoing development of health care professionals within the Central East LHIN, including, but not limited to, standardization of policies, processes and protocols with the Central East LHIN boundaries.

Hospital/CCAC Financial Leadership Group (HCFLG)
The HCFLG provides expert content-knowledge, directional leadership and expertise in financial management within a collaborative forum in accordance with Central East LHIN priorities and strategies (e.g. IHSP). At their monthly meetings, members identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

E-health Steering Committee
The Central East Local Health Integration Network's eHealth Steering Committee, which meets on a quarterly basis, has continued to provide active leadership in developing and implementing the Central East LHIN eHealth Strategy and Tactical Plan to enable LHIN health care providers to leverage the potential of Information and Communications Technology (ICT).

Wait Time Strategy Working Group

The Wait Time Strategy Working Group provides directional leadership, content-knowledge and expertise in planning and implementing specific initiatives within a collaborative forum in accordance with Central East Local Health Integration Network priorities and strategies (e.g. IHSP) as well as with the current Wait Time Strategy. The aim is to improve priority area wait times across the Central East LHIN, while easing patient flow and maintaining quality along the broader continuum of care. Also, in parallel, members utilize their role to identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

Diagnostic Imaging Working Group

Throughout 2011/12, the DI Working Group met monthly to support the Wait Time Strategy Working Group and the Central East LHIN in managing wait times related to diagnostic imaging (MRI and CT). In doing so, the group discussed and promoted best practices in quality and methods of improving efficiency (e.g. MRI PIP) across the LHIN. This year, the focus had been to explore a more coordinated, common system-wide approach to referrals and management of information. This collaborative approach to system management will continue in 2012/13.

Health Professionals Advisory Committee (HPAC)

Like all LHINs, the Central East LHIN has established a Health Professionals Advisory Committee. This committee is responsible for assisting the LHIN in carrying out its responsibilities by providing advice on how to achieve patient-centered health care.

Partnership with Public Health

In the Central East LHIN, quarterly meetings are held with the Medical Officers of Health (MOH) from the four Public Health Units in the region. Chaired by the LHIN CEO, the group discusses many topics of mutual concern, in particular the review of best practices related to infection control, outbreak and system surge management, falls prevention and smoking cessation.

Primary Care Working Group (PCWG)

The Primary Care Working Group's vision is "The Best Primary Care Everywhere." The Primary Care Working Group meets monthly and includes 18 members comprised of primary care physicians from across the LHIN, Nurse Practitioners, pharmacy and public health representatives. The Working Group is co-chaired by a physician and a non-physician lead and provides expert advice to the Central East LHIN on current and emerging trends and issues in primary health care and population health. At its monthly meetings and through the ongoing leadership of its co-chairs, the PCWG continues to work with all stakeholders and the Central East LHIN to support and promote best practices to create an efficient patient centered health care system that will better navigate our patients safely through their journey of care. Integrating the role of Primary Care into LHIN planning was further strengthened in 2011-12 when Dr. Robert Drury (Durham and Northeast) and Dr. Christopher Jyu (Scarborough) were named as Primary Care Leads for the Central East LHIN. By working together, the LHIN and local primary care health service providers are continuing to implement strategies that improve access to quality care for local residents.

Strategic Aim Coalitions

Vascular Health Strategic Aim Coalition

First established in May 2010, coalitions were formed to provide leadership to the achievement of the LHIN's Strategic Aims. The *Vascular Health Strategic Aim Coalition* is comprised of fifteen individuals from primary care, acute, community and long-term care home sectors. During 2011/12 the coalition developed a Vascular Health Strategy and Implementation Plan for Central East LHIN" to achieve the

Strategic Aim of saving 10,000 in patient days related to Vascular (including diabetes) conditions. To date the Coalition has surpassed its target and has saved 17,430 days.

Regional Specialized Geriatric Services (RSGS) entity Governance Authority
The goal of ensuring that frail seniors living in the Central East have access to a regional, integrated system of care moved forward in 2011/12 when local leaders were selected to form the inaugural Central East LHIN Regional Specialized Geriatric Services (RSGS) entity Governance Authority. The creation of the Governance Authority came after the Central East LHIN Board of Directors approved a plan to implement a regional model for the organization, coordination and governance of specialized geriatric services that builds on investments already made in areas such as geriatric assessment, geriatric emergency management and hospital activation programs. With membership from hospitals, community, long-term care, physician leadership and consumer representatives, a number of meetings have been held to begin planning for regional specialized geriatric services to develop a Strategic Plan that will be included in the LHIN's 2013-16 Integrated Health Service Plan.

Central East Transitions in Care Steering Committee
The Central East Transitions in Care Steering Committee is comprised of senior health care leaders from all sectors and focuses on business and quality improvement processes or enablers specifically related to care transitions (unlike other committees or structures that are focused on coordination of regional services – the Vascular Strategic Aim Coalition or the Central East Regional Specialized Geriatric Services Entity). The Steering Committee works with the LHIN and other health service providers/sub-committees to ensure that initiatives such as a Resource Matching and Referral (RMR) rollout and Home First processes are aligned and to support the spread of quality improvement approaches and tools.

Central East Hospice Palliative Care Network
Members of the hospice palliative care sector within Central East integrated three predecessor End-of-life Care Networks operating in Central East: Durham Region End-of-Life Care Network; Haliburton, Kawartha and Pine Ridge End-of-Life Care Network; and Toronto Palliative Care Network-East Region into the Central East Hospice Palliative Care Network under the direction of the Central East Community Care Access Centre. The Network advises both the CECCAC and the LHIN on palliative care planning and co-ordination to support the LHIN's strategic aims.

Central East BSO (Behavioural Supports Ontario) Design Team
As an Early Adopter LHIN, the Central East LHIN brought together a BSO Design Team comprised of representatives from hospital, community and long term care providers. The BSO Design Team worked with the LHIN to develop a local BSO Action Plan that led to a significant investment in the enhancement of services to improve care for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions. The Action Plan included the rollout of BSO training to over 800 front line staff, that is continuing to improve the quality of life for long-term care residents with challenging behaviours. This team will continue to support their peers in 2012/13 as the BSO model is expanded across the LHIN and into community settings.

Central East LHIN Self-Management Program Advisory Council
The Program Advisory Council was established in April 2010 to provide strategic advice on the implementation of the Self Management program, recommend partnerships with other stakeholders and review program outcomes, case studies and best practices. Meetings are held four times a year.

Central East Diabetes Network (CEDN)
Comprised of diabetes health care providers from across the Central East LHIN, members of the CEDN work together to improve access to diabetes care for local residents. The Network is also closely aligned with the Central East Diabetes Regional Co-ordination Centre (DRCC) and advises the LHIN on investments to improve care. The DRCC has identified two Diabetes and Primary Care Lead physicians,

Dr. Tom Bell and Dr. Christopher Jyu to support their activities. The DRCC also engages endocrinologists in the Central East LHIN to provide specialist consultation to under serviced communities. Under the leadership of the DRCC and the Central East CCAC, planning and implementation for the creation of Complex Diabetes Care Centres with centralized intake and triage for clients with all types of diabetes was initiated in 2011/2012.

System Surge Management Committee
The Central East LHIN System Surge Management Committee is a group of individuals comprised of hospital senior administration, LTCH senior management, ethicists, Central East CCAC senior management, the Central East LHIN Primary Care Lead, Central East LHIN Critical Care Lead, and Central East LHIN Staff (Senior Director of SDI, Communications Lead, Implementation Consultant, Health Planner). The Central East LHIN System Surge Management Committee meets bi-monthly when there is no existing surge or pending surge activity. Overall the System Surge Management Committee continued over the past year to provide an effective and efficient forum for managing and coordinating system level response to moderate surge and major surge events impacting the local health care system (surge is any health care situation where demand exceeds capacity). Furthermore, the Committee has provided an opportunity for communication and sharing of best practices between health care providers, local public health officials and others, e.g. EMS in the event of a regional/sub-regional moderate or major surge event. The Central East LHIN System Surge Management Committee is currently working on the development of a Ventilation Best Practices Protocol to ensure timely, effective and consistent use of ventilators throughout the Central East LHIN in times of surge activity.

Engagement Activities

Central East LHIN Symposium
On May 31, 2011, the Central East LHIN's held its fifth annual symposium - "Reaching the Quality Summit". Once again, this annual event provided health service providers – governors, administrators, physicians, clinical leaders and front line staff, patients/clients/consumers – with the opportunity to share best practices on health system quality initiatives that directly impact the achievement of the LHIN's strategic aims. The day long event included presentations by a number of keynote speakers, morning breakout sessions on "Navigating the Health Care System from the Patient/Caregiver Perspective", afternoon "Coaching Circles" led by peer facilitators and a joint meeting for the members of the LHIN's three Governance Advisory Councils. It also included a fascinating and motivational presentation by Laurie Skreslet, the first Canadian to reach the summit of Mt. Everest.

Open Board meetings
Board meetings and board committee meetings (Audit and Finance, Nominations and Governance) are held on a regular basis so that information can be reviewed and discussed by the Board to assist the decision making process as it supports the work of the staff of the Central East LHIN. In January 2011 the Board passed a new policy entitled "Delegations to the Central East LHIN Board" which has been developed to ensure a consistent and formal approach to evaluating requests and inviting delegations to present to the Central East LHIN Board of Directors. Materials from all the meetings continue to be posted to the Central East LHIN website and stakeholders were alerted to this posting through a web-enabled MY PAGE system.

Sector Based Providers
Targeted engagement with sector based providers in the Central East LHIN supported the sharing of information as LHINs worked with hospitals, community based agencies and long-term care homes on completing annual service accountability agreements. Information shared at these sessions was posted on the Central East LHIN website so that stakeholders from across the LHIN could see the work being done by these providers to provide accessible, efficient and quality health care services.

Physician Engagement
The Central East LHIN continued to engage with its physicians in 2011/12. An example of this is participation in annual CME events including an event at Tosca Banquet Hall in Oshawa on May 18, 2011. The LHIN also benefits from a strong relationship with its various physician leads including Dr. Robert Drury and Dr. Christopher Jyu, Primary Care LHIN Leads; Dr. Robert Kyle, Co-Chair, Central East LHIN Health Professionals Advisory Committee; Dr. Gary Mann, Emergency Medicine Physician Lead; Dr. Andrew Steele, Co-Chair, Central East LHIN Vascular Health Strategic Aim Coalition and Dr. Randy Wax, Critical Care Lead whose engagement with their physician and clinical colleagues from across the LHIN supports LHIN staff and the Board in their planning and decision making activities. A Primary Care Physician Engagement Resource Guide and Toolkit created in partnership with Ontario Medical Association and Ontario College of Family Physicians and posted on all LHINs' websites continues to provide LHINs with a range of preferred engagement techniques that can be used to strengthen physician relations and enhance collaboration.

Regional, County and Municipal Councils
The Central East LHIN continued to visit regional, county and municipal councils in 2011/12 to provide updates to local elected officials on the work being done to improve the local delivery of health care services to their residents and constituents.

MPP Engagement
Regular meetings between LHIN leadership and the Members of Provincial Parliament from all Central East ridings helped to ensure that these provincial leaders were aware of LHIN initiatives that would be benefitting their local constituents.

Speakers' Bureau
LHIN staff and board members attended a number of third-party events in 2011/12 as part of the "Speakers' Bureau." This included health service providers' Annual General Meetings, public announcements and open houses. This provides the LHIN with an opportunity to hear from local stakeholders on local issues and opportunities for improvement, but also an opportunity for the LHIN to inform the public and stakeholders.

Integration

One of the main goals of each LHIN is the integration of health care services to create a more efficient health care system while at the same time improving the health care experience by creating a seamless system of care. In 2011/12, the Central East LHIN continued to support integration activities through the following:

Organizational Health – Self Assessment Tool
The Central East LHIN self assessment tool supports community support services and community mental health and addictions agencies to quickly assess their organizational health status. Developed by the Central East LHIN and shared with all stakeholders, the tool is an important resource for a health service provider to consider as they assess whether they are effectively and efficiently providing client/patient services in an accountable manner. Completing the assessment allows agency boards and senior executive leaders to assess the health status of their organizations which may then suggest action, including integration opportunities, to mitigate the issues identified.
http://www.centraleastlhin.on.ca/Page.aspx?id=96

Voluntary, Facilitated and Negotiated Integration Process and Requirements Guides
The Central East LHIN's "Voluntary Integration Process and Requirements Guide" and its "Facilitated and Negotiated Integration Process and Requirements Guide" supports Central East LHIN funded health

service providers through the process of planning and implementing either a voluntary, facilitated or negotiated integration. We continue to share these resources with all stakeholders, including our sister LHINs as it is posted on the Central East LHIN website.
http://www.centraleastlhin.on.ca/Page.aspx?id=96

Integration Activities

In order to execute integrations, the Local Health Services Integration Act, 2006 (LHSIA), provides several tools that the LHIN, the Minister of Health and Long-Term Care and health services providers (HSPs) can use to integrate.

These include:

- Integrations through Funding where the LHIN uses its funding authority to promote integration of services;
- Facilitated and Negotiated Integrations where the LHIN and/or HSPs explore appropriate integration strategies and the LHIN facilitates or negotiates integration with the HSPs;
- Required Integrations where the LHIN orders HSPs to integrate services;
- Voluntary Integrations where a HSP, at their own initiative, plans to integrate services funded by the LHIN;
- Minister's Order where the Minister orders a HSP to integrate i.e. cease to operate, dissolve, windup its operations, amalgamate or transfer operations.with/between health service providers.

Integration accomplishments in the Central East LHIN in 2011/12 included:

Canadian Mental Health Association – North East Cluster – Facilitated Integration
With the unanimous support of both boards, the Canadian Mental Health Association (CMHA) branches in the City of Kawartha Lakes and Peterborough completed a facilitated integration process in 2011/12 to amalgamate their two branches into a new organization by April 2013.
http://www.centraleastlhin.on.ca/Page.aspx?id=19612

Regional Cardiovascular Rehabilitation Services – Voluntary Integration
Patients in Durham Region and Scarborough have greater access to co-ordinated cardiovascular rehabilitation services after the Board of the Central East LHIN approved $1 million in funding to support the voluntary integration of the cardiovascular rehabilitation programs at Rouge Valley Health System (RVHS) and Lakeridge Health. The two hospitals will work together to deliver a groundbreaking regional cardiovascular rehabilitation and secondary prevention program, which will provide services annually to an additional 680 patients per year, or a total of 1,980 residents in their communities.
http://www.centraleastlhin.on.ca/Page.aspx?id=20418

Victorian Order of Nurses (VON) – Scarborough Centre for Healthy Communities (SCHC) – Integration through Funding
In the Central East LHIN, hospice services are provided by a variety of organizations including hospitals, the Community Care Access Centre and community support service agencies. In late 2010, the LHIN worked with a number of agencies in the northeast cluster to facilitate integrations. This resulted in stand-alone hospice agencies being integrated into community care agencies that provided clients and their families with access to a broader range of services. Encouraging this type of service change, which leads to strengthened partnerships between community providers and that benefits clients and their families, has become a strategic direction of the Central East LHIN and was the approach that the LHIN took with hospice services in the Scarborough community. With the LHIN's direction, VON Toronto-York region site, which had been funded to provide community based hospice services, worked with the Scarborough Centre for Healthy Communities on a transfer of service that saw hospice services transferred from VON to SCHC effective April 1, 2012 in order to better meet the needs of its clients more efficiently. The

successful transition of these services minimized disruptions to client services and ensured ongoing volunteer engagement.

Manse Road Supportive Housing Program – Voluntary Integration
A ten-unit supportive housing service run by The Scarborough Hospital at 125 Manse Road was successfully transferred to Good Shepherd Non-Profit Homes Inc. in January 2012. The hospital and the agency worked together to develop a business case for this voluntary integration by working with existing tenants and staff to minimize any service disruption and to ensure that the transfer was as seamless as possible. Vulnerable clients requiring mental health services in a supportive housing setting continue to receive services as a result of this integration.

Spruce Corners – Facilitated Integration
Since 1993, the Board of Apsley and District Satellite Homes for Seniors (ADSHS) has provided a supportive housing service at its Spruce Corners location, 30 Simcon Crescent, Apsley. Over the years numerous people have lived in the agency's 8-unit building, supported by staff and contracted personal support workers. By providing this service, the ADSHS Board has ensured that its residents have had the ability to remain as independent as their interests allow, have received prompt effective service to meet their varying needs and have been provided with leisure time options and opportunities. The support of the Central East LHIN Board and staff in 2011/12 resulted in a facilitated integration that will see the responsibility for delivering the services transferred to the Canadian Red Cross and ownership of the home itself to the Peterborough Housing Corporation.
http://www.centraleastlhin.on.ca/Page.aspx?id=21002

Community Health Services – Facilitated Integration
On February 22, 2012, the Board of the Central East LHIN passed a motion supporting a Community Health Services Integration Strategy, a facilitated integration strategy for Community Support Services (CSS) agencies and Community Health Centres (CHCs), to commence in April 2012 and be completed by 2015. Through facilitated integrations, cluster-based groups of CSS agencies and CHCs will now participate in a phased process that aims to improve client access to high-quality services, create readiness for future health system transformation and make the best use of the public's investment by identifying integration opportunities.
http://www.centraleastlhin.on.ca/report_display.aspx?id=21752

ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE

In 2011/12 the Central East LHIN received a total operating budget of $6.5 million which included operations at $4.7 million and additional funding of $1.8 million as noted in the financial statements (note 8). The Central East LHIN exercised prudent fiscal management to balance its internal operations budget and met the objective target of less than 1% in surplus. The additional funding for special projects allowed the Central East LHIN to pursue initiatives such as Aboriginal health planning; evaluating and monitoring emergency care performance; e-Health projects and continued support to the French Language Services and Aboriginal initiatives. The Behavioural Support Ontario (BSO) project and Primary Care funding were two new initiatives this fiscal year.

The BSO project Action Plan led to a significant investment in the enhancement of services to improve care for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions. The Primary Care funding was for a Physician LHIN Lead that can advance primary care services to support timely, accessible and effective primary care and prevent unnecessary emergency department visits. The expected outcomes are to produce quantifiable improvements to individual ALC/ED targets and reduce the number of unattached patients registered with Health Care Connect.

The organizational structure of the Central East LHIN is a collaborative model which has supported the achievement of the Central East LHIN's strategic aims by improving our internal work flow processes. The assignment of co-leads acting as "points of contact" for each sector reporting to the Central East LHIN – hospitals, the CCAC, community support services and community health centres, mental health and addiction providers and long term care homes - has improved the support for issues and matters related to the sectors.

The Central East LHIN's Performance Management Program continues to ensure that all staff positions support the organization's objectives through the achievement of their specific goals and objectives and identification of development opportunities. The Central East LHIN organization is comprised of three distinct units – Corporate (Governance, Communications, Business Support); System Design and Implementation (Integration, Quality Improvement, System Planning) and System Finance and Performance Management (Finance, Performance). With additional support from Health Force Ontario and Health Quality Ontario, the staff complement of 33 FTEs effectively managed a $2 billion health service system on behalf of the residents of the Central East LHIN.

The Central East LHIN Code of Conduct, which was developed by LHIN staff throughout 2010 and adopted by the LHIN's Board of Directors in November 2010, is intended to be a central guide and reference for all employees and the Board in support of day-to-day interactions and decision making, and to help employees and the Board work more effectively together. In 2011/12, the structure to support the successful implementation of the Code included ongoing promotion with staff, development of a compliance procedure, ongoing policy development and education initiatives.
http://www.centraleastlhin.on.ca/Page.aspx?id=18896&ekmensel=e2f22e9a_72_184_18896_2

INDEPENDENT AUDITOR'S REPORT

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To the Members of the Board of Directors of the
Central East Local Health Integration Network

We have audited the accompanying financial statements of the Central East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2012, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 23, 2012

Statement of Financial Position

	2012	2011
	$	$
Financial assets		
Cash	**537,963**	1,008,629
Due from Ministry of Health and Long Term Care ("MOHLTC")	**3,093,800**	13,911,183
Accounts receivable	**273,858**	37,840
	3,905,621	14,957,652
Liabilities		
Accounts payable and accrued liabilities	**338,210**	531,482
Due to Health Service Providers ("HSP")	**3,093,800**	13,911,183
Due to MOHLTC and E-Health Ontario (Note 3b, 3c)	**509,300**	541,295
Deferred capital contributions (Note 5)	**237,523**	315,287
	4,178,833	15,299,247
Net debt	**(273,212)**	(341,595)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**35,689**	26,308
Capital assets (Note 7)	**237,523**	315,287
	273,212	341,595
Accumulated surplus	-	-

Approved by the Board

David Nichols, Audit and Finance Committee Chair

Wayne Gladstone, Chair, Board of Directors

Statement of Financial Activities

	Budget (Unaudited) (Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 8)	**1,976,494,761**	**2,129,743,201**	2,042,808,997
Operations of LHIN	**4,772,730**	**4,693,700**	4,659,791
Emergency Department ("ED") Lead (Note 10a)	-	**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") (Note 10b)	-	**100,000**	100,000
Aboriginal Planning (Note 10c)	-	**20,000**	20,000
E-Health (Note 10d)	-	**600,000**	632,000
Critical Care (Note 10e)	-	**75,000**	75,000
French Language Services (Note 10f)	-	**106,000**	170,116
Aboriginal Health Transition (Note 10 g)	-	-	47,202
Behavioural Supports Ontario Pilot (Note 10 h)	-	**750,000**	-
Primary Care (Note 10 i)	-	**43,750**	-
Amortization of deferred capital contributions (Note 5)	-	**156,794**	166,962
	1,981,267,491	**2,136,363,445**	2,048,755,068
Funding repayable to the MOHLTC (Note 3a)	-	**(509,300)**	(541,295)
	1,981,267,491	**2,135,854,145**	2,048,213,773
Expenses			
Transfer payments to HSPs (Note 9)	**1,976,494,761**	**2,129,743,201**	2,042,808,997
General and administrative (Note 11)	**4,772,730**	**4,821,126**	4,748,677
ED Lead (Note 10a)	-	**72,161**	69,290
ER/ALC (Note 10b)	-	**100,000**	96,714
Aboriginal Planning (Note 10c)	-	**3,882**	-
E-Health (Note 10d)	-	**422,449**	356,450
Critical Care (Note 10e)	-	**72,000**	72,000
French Language Services (Note 10f)	-	**49,290**	51,665
Aboriginal Health Transition (Note 10g)	-	-	9,980
Behavioural Supports Ontario Pilot (Note 10 h)	-	**551,905**	-
Primary Care (Note 10 i)	-	**18,131**	-
	1,981,267,491	**2,135,854,145**	2,048,213,773
Annual surplus and closing accumulated surplus	-	-	-

Statement of Changes in Net Debt

	Budget (Unaudited) (Note 8)	2012	2011
		$	$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	**(79,030)**	(112,939)
Amortization of tangible capital assets	-	**156,794**	166,962
Change in other non-financial assets	-	**(9,381)**	22,824
Increase in net debt	-	**68,383**	76,847
Opening net debt	-	**(341,595)**	(418,442)
Closing net debt	-	**(273,212)**	(341,595)

Statement of Cash Flows

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**156,794**	166,962
Amortization of deferred capital contributions (Note 5)	**(156,794)**	(166,962)
	-	-
Changes in non-cash operating items		
Increase (decrease) in due from MOHLTC	**10,817,383**	(12,377,683)
(Decrease) increase in accounts receivable	**(236,018)**	1,154,624
(Decrease) in accounts payable and accrued liabilities	**(193,272)**	(891,883)
(Decrease) increase in due to HSPs	**(10,817,383)**	12,377,683
(Decrease) increase in due to the MOHLTC	**(31,995)**	187,026
(Decrease) Increase in prepaid expenses	**(9,381)**	22,824
	(470,666)	472,591
Capital transactions		
Acquisition of tangible capital assets	**(79,030)**	(112,939)
Financing transactions		
Capital contributions received (Note 5)	**79,030**	112,939
Net increase (decrease) in cash	**(470,666)**	472,591
Cash, beginning of year	**1,008,629**	536,038
Cash, end of year	**537,963**	1,008,629

Notes to the Financial Statements

1. Description of business

The Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN ("CE LHIN") is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park. The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio- demographic characteristics. The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC. The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN's financial statements do not include any MOHLTC managed programs.

The CELHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The CELHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable, expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Funding payments to Health Service Providers in the LHIN geographic area flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2012.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method Leasehold improvements
Life of lease straight-line method Office furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the TPA, the CELHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC or to eEhealth Ontario, respectively.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received $	Eligible expenses $	2012 Excess funding $	2011 Excess funding $
Transfer payments to HSPs	2,129,743,201	2,129,743,201	-	-
LHIN operations	4,850,494	4,821,126	29,367	78,076
ER/ALC	100,000	100,000	-	3,286
ED/Lead	75,000	72,161	2,839	5,710
Critical Care	75,000	72,000	3,000	3,000
E-Health	600,000	422,449	177,551	275,550
Aboriginal Planning	20,000	3,882	16,118	20,000
French Language Services	106,000	49,290	56,710	118,451
Aboriginal Health Transition	-	-	-	37,222
Behavioural Supports	-	-	-	-
Ontario	750,000	551,905	198,095	-
Primary Care Lead	43,750	18,131	25,619	-
	2,136,363,445	2,135,854,145	509,300	541,295

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2012 $	2011 $
Due to MOHLTC, beginning of year	541,295	354,269
Recovery by MOHLTC during the year	(541,295)	(354,269)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	331,749	541,295
Due to MOHLTC, end of year	331,749	541,295

c) The amount due to the eHealth Ontario at March 31 is made up as follows:

	2012 $	2011 $
Due to eHealth Ontario, beginning of year	-	-
Paid to eHealth Ontario during year	-	-
Funding repayable to the eHealth Ontario related to current year activities (Note 3a)	177,551	-
Due to eHealth Ontario, end of year	177,551	-

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all

the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2012 $	2011 $
Balance, beginning of year	315,287	369,310
Capital contributions received during the year	79,030	112,939
Amortization for the year	(156,794)	(166,962)
Balance, end of year	237,523	315,287

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due to 2017 are as follows:

	$
2013	236,537
2014	232,949
2015	228,331
2016	133,193
2017	-
	831,010

The LHIN also has funding commitments to HSPs associated with accountability agreements. The Transfer Payment Planning Targets to HSPs based on the current accountability agreements are as follows:

	$
2013	2,088,200,455
2014	2,088,200,455

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	521,361	420,080	101,281	81,686
Computer equipment	268,615	244,260	24,355	68,137
Web development	36,100	28,507	7,593	-
Leasehold improvements	668,028	563,734	104,294	165,464
	1,494,104	1,256,581	237,523	315,287

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the

year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $2,129,743,201 is made up of the following:

	$
Initial HSP funding budget	1,976,494,761
Adjustment due to announcements made during the year	153,248,440
Total HSP funding budget	2,129,743,201

The total revised operating budget of $6,542,480 is made up of the following:

	$
Initial budget as represented on the statement of financial activities	4,772,730
Additional funding received for one time initiatives:	
ER/ALC	100,000
ED/Lead	75,000
Critical Care	75,000
E-Health	600,000
Aboriginal Planning	20,000
French Language Services	106,000
Behavioural Supports Ontario Pilot Project	750,000
Primary Care	43,750
Total budget	6,542,480

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $2,129,743,201 (2011 - $2,042,808,997) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2012 as follows:

	2012	2011
	$	$
Health Infrastructure Renewal Fund	-	3,271,065
Operation of hospitals	1,252,096,815	1,206,183,380
Grants to compensate for municipal taxation - public hospitals	283,200	286,275
Long term care homes	410,848,439	387,840,154
Community care access centres	227,764,449	217,505,556
Community support services	32,615,566	29,881,514
Assisted living services in supportive housing	13,809,205	13,675,055
Community health centres	20,843,048	19,816,160
Community mental health addictions program	57,930,372	54,169,878
Specialty psychiatric hospitals	112,077,447	108,726,800
Acquired brain injury	1,450,060	1,428,560
Grants to compensate for municipal taxation - psychiatric hospitals	24,600	24,600
	2,129,743,201	2,042,808,997

The 2010/11 allocation represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2010/11 under the 2010/11 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2010/11 HIRF Guidelines which the ministry has provided to LHINs. In 2011/12, HIRF grants were allocated as Ministry managed funds.

10. Separate funding amounts were received by the CELHIN from the MOHLTC and eHealth Ontario for specific initiatives

a) ED Lead

The LHIN received funding of $75,000 (2011 - $75,000) related to the ED Lead project. ED Lead expenses incurred during the year are as follows:

	2012 $	2011 $
Consulting services	**72,000**	69,290
Other	**161**	-
	72,161	69,290

b) ER/ALC

The LHIN received funding of $100,000 (2011 - $100,000) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of $93,570 (2011 - $96,714) of salaries & benefits and $6,430 (2011 - $nil) of other expenses.

c) Aboriginal Planning

The LHIN received funding of $20,000 (2011 - $20,000) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of $nil (2011 - $nil) of consulting fees and $3,882 (2011 - $nil) of other expenses.

d) E-Health

The LHIN received funding of $600,000 (2011 - $632,000) related to the E-Health project. E-Health project expenses incurred during the year are as follows:

	2012 $	2011 $
Consulting services	**20,006**	19,301
Salaries and benefits	**290,314**	308,718
Meetings	**18,468**	-
Supplies and other	**93,661**	28,431
	422,449	356,450

e) Critical Care

The LHIN received funding of $75,000 (2011 - $75,000) related to the Critical Care project. Critical Care project expenses incurred during the year consist of $72,000 of consultant expenses (2011 - $72,000).

f) French Language Services

The LHIN received funding of $106,000 (2011 - $170,116) related to the French Language project. French Language project expenses incurred during the year consist of $49,290 of salaries and benefits (2011 - $51,665).

g) Aboriginal Health Transition Funding

The LHIN received funding of $nil (2011 - $47,202) related to the Aboriginal Health Transition Funding project. Aboriginal Health Transition Funding project expense (recovery) incurred during the year consist of $ nil of meeting expenses (2011 - $9,980).

11. Separate funding amounts were received by the CELHIN from the MOHLTC and eHealth Ontario for specific initiatives (continued)

h) Behavioural Supports Ontario Pilot Project

The LHIN received funding of $750,000 (2011 - $nil) related to the Behavioural Supports Ontario Pilot Project. Behavioural Supports Ontario Pilot Funding Project expenses incurred during the year consist of $150,296 of consulting expenses (2011 - $nil), $ 223,720 (2011 - $nil) of salaries & benefits, $74,326 (2011 - $nil) of meeting expenses and $ 103,563 (2011 - $nil) of other expenses.

i) Primary Care

The LHIN received funding of $43,750 (2011 - $nil) related to the Primary Care project. Primary Care project expenses incurred during the year consist of $18,000 (2011 - $nil) of consulting fees and $131 (2011 - $nil) of meeting expenses.

12. General and administrative expenses

The Statement of financial activities presents the expenses by function, the following classifies these same expenses by object:

	2012	2011
	$	$
Salaries and benefits	**3,441,389**	3,328,839
Occupancy	**282,431**	382,055
Amortization	**156,794**	166,962
Shared services	**501,995**	409,495
Community engagement	**88,617**	73,075
Consulting services	**57,418**	71,891
Supplies	**98,524**	106,584
Board member expenses	**103,146**	120,625
Mail, courier and telecommunications	**2,211**	1,670
Other	**88,601**	87,481
	4,821,126	4,748,677

Included in general and administrative expenses are board per diems and expenses as follows:

	2012		
	Budget	2012	2011
	$	$	$
Board chair per diem expense	**50,000**	**50,957**	41,300
Other board members per diem expense	**100,000**	**25,419**	58,947
CRA accrual historical expense	**-**	**-**	(12,729)
Governance costs and travel	**70,000**	**26,770**	33,106
Total expenses	**220,000**	**103,146**	120,625

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 33 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $270,985 (2011 - $258,290) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation of the plan was completed for the plan at of December 31, 2011. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

15. Comparative figures

Certain comparative figures have re-classified to conform to the current year presentation.

STAFF MEMBERS

Back Row
Suzette Stines-Walford, Jai Mills, Ritva Gallant, Emily Van de Klippe, Marilee Suter, Sheila Rogoski, Brian Laundry

2nd Middle Row
Alex Ruppert, Dieufert Bellot, Brittany Peterson, Jeanne Thomas, Marlene Ross, Jennifer Kerswill, Indra Narula, Lauren Chitra, Naj Hassam, Tapas Kar

1st Middle Row
Christine Laity, Dana Lian, Kate Reed, Jina Mintsinikas, Jennifer Persaud, Linda Henry, Lisa Lambert, Karen O'Brien, Katie Cronin-Wood

Front Row
James Meloche, Paul Barker, Deborah Hammons

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Marco Aguila, Janet Boland, Amanda English, Carolyn Kanhai, Ajay Thusoo, Charli Law

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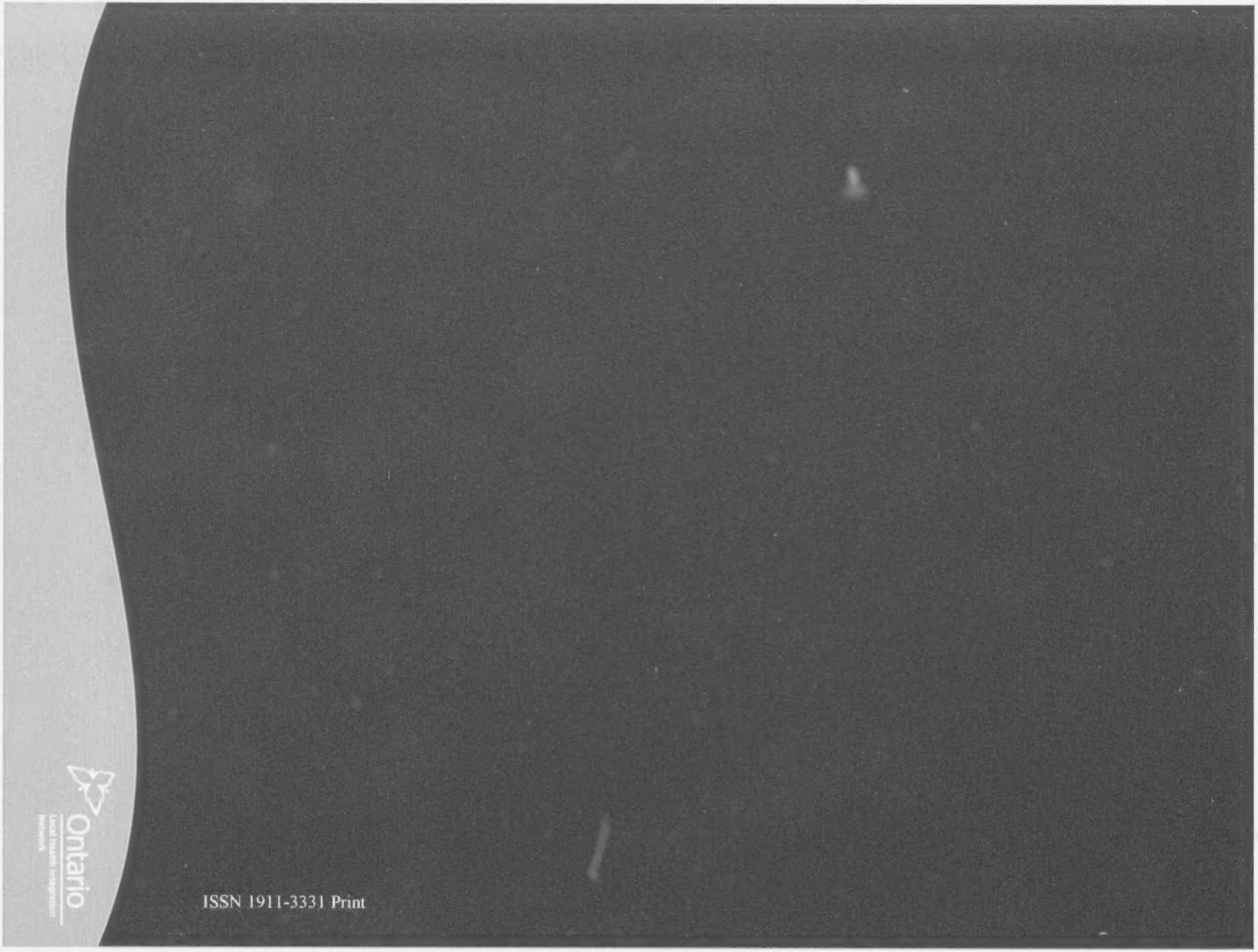

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